LETTERS *to the Editor*

More on Community Mental Health

TO THE EDITOR: Drs. Langsley and Barter, in their special article on Community Mental Health in California in the March issue [West J Med 122:271-276, Mar 1975], state that the major factor in the reduction of state hospital admission rates is the ability of the community programs to provide a full range of treatment.

There are many who would question this and attribute the lower rate to the Lanterman-Petris-Short Act which limits involuntary admission to state hospitals to those who are actively dangerous to themselves or others or so severely disabled as to not be able to care for themselves. Furthermore, voluntary admissions must be approved by the local mental health authority.

What isn't mentioned is the increased number of severely ill patients who are housed in board and care homes in communities that in many instances provide less in the way of treatment or rehabilitation than the state hospitals ever did. Communities have been "educated" to tolerate deviant behavior rather than correct or treat it.

It would be interesting to know the extent to which the percentage of patients (formerly able to receive treatment in state hospitals) receiving welfare and total disability compensation has increased and the extent to which psychopathology and disability have been reduced by the comprehensive forward-looking community program such as has been developed in Sacramento County. These questions are raised not in criticism of the worthwhile goal of treating patients in their communities, nor in defense of the many deficiencies that characterized previous approaches, but in the hope that truly valid criteria are developed for measuring and comparing the results of different treatment approaches. A change of locus in treatment is not in itself a valid criterion of success of a program. What have the changes been in mental health?

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Vietnamese Refugee Children

TO THE EDITOR : The sudden influx of South Vietnamese orphans into our area has created the need for rapid dissemination of pertinent information to physicians who might be caring for these youngsters. Since I have not yet seen such information available, I would like to comment briefly on observations that I've made in seeing these children in South Vietnam in 1973 and now in my private practice of pediatrics. It is indeed important for any doctor caring for an orphan and his new family to spend extra time in considering the medical and psychological problems that the child may have, and in discussing the appropriate preventive and treatment factors with the parents.

The *"history"* that accompanies the child can be very misleading. Even the age of the orphan may be inaccurate, as the Vietnamese consider the child to be one year old at birth, increasing in age at each Tet New Year. Immunization records can usually be ignored; any vaccine given (if it indeed was actually given) might well have been outdated or attenuated by lack of proper storage. BCG tests are often given—so a positive TB skin test may be quite misguiding.

What we do know about the usual history of these children is more important to consider. The rampant malnutrition, manifested by anemia and lower serum albumin levels serves as a basis for many diseases not frequently seen in our private practices, but which must be considered upon the examination of any Indochinese orphan: tuberculosis, Pneumocystis carinii, are among those frequently encountered. Deaths from tuberculous peritonitis and Pneumocystis carinii are prevalent in Vietnam; cases of Pneumocystis carinii have already been reported among these children after arrival in the U.S.

We should all be aware that the parasitic infestations are widespread; however, we should keep in mind that typhoid and paratyphoid, amebiasis, hepatitis, measles, diphtheria, tetanus, dengue, and severe cases of chickenpox (not smallpox!) fill the hospital wards in Saigon.

I would like to recommend as baseline laboratory studies for all initial visits of these children: